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Medicare Part D Payment Demonstration Focus Group Report

Final Report

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EXECUTIVE SUMMARY

Under Medicare Part D, catastrophic coverage is provided by Medicare to limit plan liabilities and beneficiary out-of-pocket costs for prescription drugs. Catastrophic coverage begins after the beneficiary's true out-of-pocket costs (TrOOP) reaches a statutory limit which in 2006, TrOOP was set at \$3,600. Costs above the catastrophic limit are split three ways: 80 percent is paid by the government through reinsurance to the plan, 15 percent is paid by the Part D plan, and the beneficiary pays the greater of a 5 percent co-insurance, or co-payments of \$2 for generic drugs and \$5 for non-generic drugs.

The Conference Report for the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 expressed concern that the structure of reinsurance might provide a disincentive for prescription drug plan sponsors to offer enhanced alternative drug coverage. Conferees suggested that the Centers for Medicare & Medicaid Services (CMS) use its demonstration authority to "allow private sector plans maximum flexibility to design alternative prescription drug coverage" (House Ways and Means, 2003). In response to these concerns, CMS launched a five-year Medicare Part D Payment Demonstration¹ allowing plans to choose alternative payment methodologies for reinsurance. The purpose of this overall project is to evaluate the impact of this demonstration on beneficiaries, sponsors and Medicare program costs.

One aspect of the evaluation is determining whether Medicare beneficiaries enrolled in demonstration plans considered similar factors in choosing their plans, and/or had different experiences compared to enrollees in non-demonstration plans. Differences in demonstration and non-demonstration plans might be found not only in the benefits offered (which was analyzed in a separate report for this project), but also in the enrollment process, the level of education and support offered, and in the experience of beneficiaries in receiving benefits. To investigate whether there appear to be any of these types of differences in experiences of beneficiaries between demonstration and non-demonstration plans, the overall evaluation included a series of focus groups with beneficiaries. This report summarizes the findings of these beneficiary focus groups.

Background

A participating prescription drug plan in the demonstration may choose one of the following three demonstration reinsurance payment options: (1) fixed capitation option; (2) flexible capitation option; and (3) MA rebate option. Demonstration plans under the fixed and flexible options "must provide a supplemental benefit that reduces or eliminates cost sharing including cost sharing in the deductible, between the deductible and initial coverage limit and/or in the coverage gap" (CMS, 2005b). The two capitation options replace the reinsurance subsidy of 80 percent of allowed costs after the beneficiary has \$3,600 in TrOOP with a capitation

¹ Because the demonstration allows for a change in the Part D reinsurance payment methodology, the demonstration was originally called the Medicare Part D Reinsurance Demonstration. Thus, in this report we sometimes refer to the Medicare Part D Payment Demonstration as the "Medicare Part D Reinsurance Demonstration."

amount reflecting the actuarial value of that subsidy if offered under the standard benefit. The distinction between the “fixed” and the “flexible” capitation options is that catastrophic coverage is required to begin at \$5,100 of total drug expenditures for a beneficiary in the “fixed” option. The “flexible” option permits catastrophic coverage to begin at any point when the beneficiary has \$3,600 in TrOOP (CMS, 2005b,c).

The MA rebate option requires the MA plan to use rebate funds from the Part C bidding process to cover the additional cost of supplemental coverage. The supplemental benefit must fill in all or part of the standard benefit’s coverage gap. This option permits the supplemental benefits that fill in the coverage gap to count toward the accumulation of the beneficiary’s TrOOP. Under this option, reinsurance will be paid in a manner similar to non-demonstration Part D plans, 80 percent of allowed costs after the beneficiary has \$3,600 in TrOOP for 2006 (CMS, 2005b,c).

For this project, RTI conducted a total of 12 focus groups in four separate locations: New York, NY, West Palm Beach, FL, Los Angeles, CA, and Greybull, WY. The first three cities were chosen as they had a large number of demonstration participating and non-participating plans, and a sufficient enrollee population both in demonstration and non-demonstration plans. These three areas also represented different geographic areas of the country. The fourth location, Greybull, WY, was chosen as it is a distinctly rural site. Because beneficiaries residing in rural areas face challenges in terms of availability of plans and information, it was important for this evaluation to solicit the views of rural beneficiaries.

To be eligible to participate in the focus groups, beneficiaries had to be presently enrolled in a Medicare prescription drug plan during the calendar year 2006. Potential participants were recruited into one of three groups:

- Group A: enrollees in a demonstration Medicare Advantage prescription drug plan (MA-PD)
- Group B: enrollees in a demonstration standalone prescription drug plan (PDP)
- Group C: enrollees in a non-demonstration MA-PD or PDP.

Findings

The results focus on similarities and differences noted in the perspectives of beneficiaries in Groups A and B (demonstration plan enrollees) compared to Group C (non-demonstration plan enrollees).

There were a number of important differences among the enrollees in demonstration versus non-demonstration plans:

- **Enrollees in demonstration plans were much more aware of having a range of choices, particularly choices among basic and enhanced benefit packages.** Demonstration plan enrollees across all sites (Groups A and B) appear to have engaged in a much more deliberate process for making a Part D plan choice.
- **Enrollees in demonstration plans were generally more knowledgeable about Part D plan benefit details.** With the exception of non-demonstration plan enrollees in West Palm Beach, Group C enrollees knew much less about key Part D plan features (such as the coverage gap).
- **Enrollees in the demonstration plans, based on their self-descriptions, appeared on average to be healthier and consume fewer drugs than the non-demonstration enrollees.** It was expected that enrollees in demonstration enhanced plans to have greater drug needs compared to the non-demonstration enrollees who were overwhelmingly enrolled in basic plans. The opposite appeared to be true; that demonstration plan enrollees described themselves generally as needing fewer drugs than many of the non-demonstration enrollees, who commonly described themselves as having complex medical needs and requirements for a wide range of drugs. This finding might be explained by a greater representation of higher income beneficiaries, with better on average health status, having a greater ability to pay higher enhanced plan premiums.

The limitations of focus group analysis do not allow us to definitively identify reasons for these observed differences among the groups. However, we were able to identify a number of potential explanations. First, enrollees in demonstration plans are, by definition, all enrolled in enhanced plan products. These products are often (but not always) more expensive than comparable products available in the marketplace. Therefore, beneficiaries willing to pay additional money may also have been more willing to invest time and energy in gathering information to make an informed choice. Second, though we have no direct evidence, organizations that chose to participate in the demonstration in order to offer enhanced benefits might also have done a better job of educating potential enrollees about their products and those product features. Third, beneficiaries receiving government subsidies were eligible to enroll in only basic plans (unless they chose to pay higher premiums, which few have). These beneficiaries of lower socioeconomic status may have either been auto assigned to plans, and/or, because of the subsidies they receive, had little incentive to choose carefully among plan choices

The beneficiaries in all the focus groups expressed the following regarding the Part D program as designed in the MMA by Congress:

- **The Part D program is confusing.** Participants in all focus groups found the program complicated and difficult to understand.
- **The coverage gap should be eliminated.** Beneficiaries thought this was a real hardship for beneficiaries, who have a hard time affording their drugs or even planning their costs.

- **Medicare beneficiaries complained about the price they had to pay for drugs once the coverage gap was reached.** The groups differed, however, on how they thought this should be accomplished. Participants in Groups A and B often suggested that the government should directly negotiate with the pharmaceutical drug makers for cheaper prices along the lines of the Canadian model. Participants in Group C were less specific, but thought prices were too high.
- **Beneficiaries were confused over how an individual reaches the gap in coverage.** The beneficiaries had the mistaken thought that the coverage gap was reached once they paid in 2006 \$2,250 in out-of-pocket costs and the beneficiaries were surprised to learn that it was a combination of total drug costs paid by the plan and beneficiary. In the West Palm Beach site, all Group C participants had this false impression about encountering the coverage gap.
- **Beneficiaries were eventually able to get needed medications.** We often heard that this process could be complicated, and that the prices that were paid for some drugs (particularly brand name) were sometimes high. Still, across groups, it appears that beneficiaries generally felt they were able to get what they needed.

SECTION 1 INTRODUCTION

1.1 Background

The purpose of this overall project is to evaluate the Centers for Medicare & Medicaid Services' (CMS') Medicare Part D Payment Demonstration.¹ One aspect of the evaluation is determining whether Medicare beneficiaries enrolled in demonstration plans considered similar factors in choosing their plans, and/or had different experiences with their benefits compared to enrollees in non-demonstration plans. Differences in demonstration and non-demonstration plans might be found not only in the benefits offered (which we have analyzed in a separate report for this project), but also in the enrollment process, the level of education and support offered, and in the experience of beneficiaries in receiving benefits. To investigate how experiences of beneficiaries in demonstration and non-demonstration plans might differ, our overall evaluation included a series of focus groups with beneficiaries. This report summarizes the findings of these beneficiary focus groups.

Beneficiary experiences in using Medicare Part D benefits are of interest to this evaluation, in part because the benefit is quite complex. For 2006 the Part D defined standard prescription drug benefit, with an average premium of about \$32 per month for basic benefits, includes an annual \$250 deductible that the beneficiary is responsible for paying. Between \$250 and the initial coverage limit of \$2,250 in total drug costs, the Part D plan is responsible for 75 percent of costs and the beneficiary pays a 25 percent coinsurance. Beneficiaries are responsible for all costs between the initial coverage limit and the beginning of catastrophic coverage (attachment point), which corresponds to a \$3,600 threshold in true out-of-pocket costs (TrOOP).² Costs in catastrophic coverage are split three ways, with the government providing reinsurance equal to 80 percent, the Part D plan covering 15 percent, and the beneficiary paying the higher of a 5 percent co-insurance, or co-payments of \$2 for generic drugs and \$5 for non-generic drugs.

Coverage for the prescription drug benefit is provided either through standalone prescription drug plans (PDPs), which offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA-PDs), which offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Part C of Medicare. Standalone PDPs must offer a basic prescription drug benefit, and MA-PDs must offer either a basic benefit or broader coverage for no additional cost. If this required level of

¹ Because the demonstration allows for a change in the Part D reinsurance payment methodology, the demonstration was originally called the Medicare Part D Reinsurance Demonstration. Thus, in this report we sometimes refer to the Medicare Part D Payment Demonstration as the "Medicare Part D Reinsurance Demonstration."

² A payment for a prescription drug will constitute an "incurred cost" and could count toward a beneficiary's TrOOP threshold only if the payment is made by or on behalf of the beneficiary. Assistance with Part D cost-sharing from a state pharmaceutical assistance program or from a charity generally will count toward the TrOOP threshold. However, if the beneficiary is reimbursed for the costs by insurance, a group health plan, or other third-party arrangement, the costs do not count toward the TrOOP threshold. Payments for drugs that are not included on the plan formulary also do not count toward the TrOOP threshold (Covington & Burling, 2005).

coverage is offered, PDPs or MA-PDs may also offer supplemental prescription drug benefits through enhanced alternative coverage for an additional premium, or MA-PDs may use Part C rebate credits to buy the supplemental premium either fully or partially down.

Government payments to Part D plans are made through the following four mechanisms (CMS, 2005a): (1) the direct subsidy equals the standardized bid amount, adjusted for the risk characteristics of the enrollee, minus the monthly beneficiary premium for basic benefits; (2) reinsurance subsidies are equal to 80 percent of the allowable reinsurance costs attributable to prescription drug costs after the Part D enrollee has incurred TrOOP that exceed the annual out-of-pocket threshold; (3) low-income subsidies are government payments on behalf of certain beneficiaries based on their income and asset levels that cover part or all of the premium subsidy amount and plan cost sharing; and (4) risk sharing arrangements involve symmetrical risk corridors in which the government either pays more of plan costs or recovers payments when a plan has allowable risk corridor costs above or below a target amount by certain percentages respectively.

1.2 Understanding of the Medicare Part D Payment Demonstration

The project focuses specifically on evaluating the impacts of the Medicare Part D Reinsurance Demonstration. Some stated goals of government-provided reinsurance programs include reducing health care premiums, promoting premium stability, and reducing the number of uninsured (American Academy of Actuaries, 2005). The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 Conference Committee Agreement (House Ways and Means, 2003) noted, however, that “the conditions under which the government provides reinsurance subsidies may create significant disincentives for private sector plans to provide supplemental prescription drug coverage.” To illustrate the Conference Committee’s concern, assume a PDP was to offer a supplemental policy that eliminated the coverage gap in the standard benefit. The beneficiary first pays a \$250 deductible, and then 25 percent coinsurance until the attachment point for catastrophic coverage of \$3,600 in TrOOP is reached, which corresponds to \$13,650 in total drug expenditures.¹ The plan in effect does not receive \$6,840 in reinsurance subsidies $[(\$13,650 - \$5,100) \times 0.8 = \$6,840]$. This illustration shows the Conference Committee’s concerns that the Part D reinsurance program provides a significant financial disincentive for plans to provide supplemental coverage, which in theory could have jeopardized beneficiary choices of, and access to, supplemental prescription drug policies. To address this concern, the Conference Committee suggested use of the Secretary’s authority to “allow private sector plans maximum flexibility to design alternative prescription drug coverage.” The Conference Committee specifically stated that “CMS should demonstrate the effect of filling in the gap in coverage by reimbursing participating plans a capitated payment that is actuarially equivalent to the amount that plans would otherwise receive from the government in the form of specific reinsurance when an individual plan enrollee reaches the catastrophic attachment point.”

¹ For the standard benefit in 2006, the beneficiary also first pays a \$250 deductible, and then 25 percent coinsurance until the initial coverage limit of \$2,250 in total drug costs is reached. From the initial coverage limit of \$2,250 until the attachment point for catastrophic coverage of \$3,600 in TrOOP is reached the beneficiary has no coverage. Under the standard benefit, \$3,600 in TrOOP corresponds to \$5,100 in total drug expenditures assuming the beneficiary had no other source of coverage.

As discussed above, under the Part D program, participating organizations have the options of offering basic versus enhanced benefits. There are also variants of basic and enhanced benefits. These variants of plan offerings are important in understanding the full range of options available to beneficiaries, and are an element to be considered in evaluating the impact of the reinsurance demonstration on the range and type of plan options. Among basic plan variants, the Part D **standard defined benefit** in 2006 consists of (1) a \$250 deductible, (2) 75 percent coverage (25 percent coinsurance) up to an initial coverage limit of \$2,250 in total drug costs, (3) a gap in the coverage in which there is no coverage, and (4) a catastrophic benefit of 95 percent coverage once out-of-pocket spending of \$3,600 has been incurred. Sponsoring organizations also had the flexibility to offer an actuarial equivalent benefit to the standard defined benefit. The two types of actuarial equivalent plans are (1) standard coverage with **actuarially equivalent** cost sharing and (2) **basic alternative coverage**. “Actuarially-equivalent” plans have a similar overall structure to the defined standard benefit, but the cost sharing differs from the 25 percent coinsurance under the standard defined benefit. These actuarially-equivalent plans might have tiered co-payments of a low dollar amount for a generic drug and higher amounts for preferred brand-name drugs and for non-preferred brand-name drugs. Under the “basic alternative coverage model”, plans have a different overall structure of the benefit, though they must be actuarially equivalent to the standard benefit. In this basic alternative coverage design, features such as a reduction in the deductible, changes in cost-sharing, and a modification of the initial coverage limit can be combined and still provide coverage with an actuarial value equal to standard coverage.

In addition to the standard defined benefit and its two actuarial equivalent variants, PDPs and MA-PDs were also able to offer **enhanced alternative** prescription coverage that exceeds standard coverage by offering supplemental benefits such as an increase in the initial coverage beyond the standard \$2,250 in 2006. On February 25, 2005, CMS announced in the Federal Register (Vol. 70, No. 37) the opportunity to participate in the Part D Payment Demonstration. The primary goal of the demonstration is to increase the number of offerings of supplemental benefits through these enhanced alternative coverage plans. The Instructions for the Part D Payment Demonstration (CMS, 2005b, c) provide an overview of the design of the demonstration, including a description of the following three demonstration options: (1) fixed capitation option, (2) flexible capitation option, and (3) MA rebate option. Demonstration plans under the fixed and flexible options “must provide a supplemental benefit that reduces or eliminates cost sharing including cost sharing in the deductible, between the deductible and initial coverage limit and/or in the coverage gap” (CMS, 2005b). All PDPs and MA-PDs are eligible to participate in certain options with the exception of the following: Program of All Inclusive Care for the Elderly (PACE), MA-PDP employer only plans, and employer direct contract plans. This demonstration will be limited to a 5-year period, 2006 through 2010.

Generally, under the reinsurance demonstration for 2006, the capitation options replace the typical reinsurance subsidy of 80 percent of allowed costs after the beneficiary has \$3,600 in TrOOP with a capitation amount reflecting the actuarial value of that subsidy if offered under the standard benefit. The distinction between the “fixed” and the “flexible” capitation options is that catastrophic coverage is required to begin at \$5,100 of total drug expenditures for a beneficiary in the “fixed” option assuming the beneficiary had no other source of coverage. The “flexible” option permits catastrophic coverage to begin at any point when the beneficiary has \$3,600 in TrOOP. Thus, other things equal, plans would tend to have less risk under the flexible option

than under the fixed option,¹ and beneficiaries with chronic, high-cost utilization of prescription drugs would tend to choose the fixed option over the flexible option. For the MA rebate option, the rebate credits from the Part C bidding process must cover all the additional cost of supplemental coverage. The MA rebate option permits supplemental benefits that fill in the coverage gap to count toward TrOOP. In this option, reinsurance will be paid in a manner similar to non-demonstration Part D plans (CMS, 2005b,c).²

The overall evaluation will examine the impact of the demonstration on beneficiaries, drug plan sponsors (PDPs and MA-PDs), and Medicare program costs. From the beneficiary perspective, the evaluation will focus on the availability of, and enrollment in, enhanced alternative benefit packages offered by drug plan sponsors, as well as patterns of utilization of enrollees. The evaluation will also explore the advantages and disadvantages of participation from the perspective of drug plan sponsors (Federal Register, Vol. 70, No. 37).

1.3 Purpose of this Focus Group Report

As part of the overall demonstration evaluation, RTI conducted focus groups with beneficiaries in four regions across the country, including one rural area. The purpose of the focus groups was to determine whether there were differences in the experiences of beneficiaries enrolled in demonstration plans versus enrollees in non-demonstration plans—differences beyond the varying benefit levels. In particular, we were interested in whether we could detect differences in how beneficiaries chose their plans, estimates of the level of information available, their ability to understand and utilize their Part D benefit, and their relative satisfaction with their plans. Focus groups were based on a detailed discussion protocol. A copy of this protocol is attached as Appendix A to this report. The main topics of the focus group discussions were the following:

- decision process for choosing a Part D plan
- beneficiary experiences with Part D plans
- beneficiary satisfaction with Part D plans.

This report summarizes our findings from the focus group discussions organized by each of these discussion areas.

¹ With the fixed option, catastrophic coverage begins at \$5,100 of beneficiary total drug spending assuming the beneficiary had no other source of coverage, and plans are liable for 95 percent of drug costs from that point (the beneficiary pays higher of 5 percent or co-payments of \$2 for generic drugs and \$5 for non-generic drugs). With the flexible option, catastrophic coverage begins at a higher level of total beneficiary drug spending; below the catastrophic level, plan benefit designs are such that they are generally liable for less than 95 percent of drug costs.

² Demonstration plans must also offer a basic coverage plan, and MA-PDs choosing one of the capitated options are under the same requirement, but they may buy down all or part of the additional premium with Part A/B rebate dollars.

SECTION 2 METHODS

2.1 Overall Design

For this project, RTI conducted a total of 12 focus groups in four locations: New York, NY, West Palm Beach, FL, Los Angeles, CA, and Greybull, WY. The first three cities were chosen because they had a large number of demonstration participating and non-participating plans, and a sufficient enrollee population both in demonstration and non-demonstration plans and because they represented different geographic areas of the country. The fourth location, Greybull, WY, was chosen as it is a distinctly rural site. Because beneficiaries residing in rural areas face challenges in terms of availability of plans and information, we believed it was important for this evaluation to solicit the views of rural beneficiaries.

To conduct the beneficiary recruiting, arrange for logistics, and moderate the focus groups, RTI subcontracted with The Henne Group. Jeff Henne, President of The Henne Group, has extensive experience as a focus group moderator for research projects in health, pharmaceuticals, and social services.

To be eligible to participate in the focus groups, beneficiaries had to be presently enrolled in a Medicare prescription drug plan during the calendar year 2006. Potential participants were recruited into one of three groups:

- Group A: enrollees in a demonstration Medicare Advantage prescription drug plan (MA-PD)
- Group B: enrollees in a demonstration standalone prescription drug plan (PDP)
- Group C: enrollees in a non-demonstration MA-PD or PDP.

Because demonstration participating plans had to offer an enhanced product, by definition, both Group A and Group B participants were enrolled in an enhanced drug plan. Specifically, Group A participants were enrolled in a prescription drug plan administered through a Medicare Advantage plan (e.g., local health maintenance organization [HMO], local preferred provider organization [PPO], regional PPO, private fee-for-service [PFFS]). Therefore, these participants were receiving both their medical coverage and prescription drug coverage through the same Medicare Advantage plan. Group B participants were enrolled in a standalone PDP for their drug coverage but were still enrollees of Original Medicare (Parts A and B). Participants in this group may also have been enrolled in a Medicare supplemental plan (Medigap) that provided additional coverage for their medical care, or been receiving additional benefits through an employer. Group C participants were enrolled in some type of prescription drug plan that was not participating in the demonstration. These drug plan types included basic (basic plans include defined standard, actuarial equivalent, and basic alternative) or enhanced MA-PDs or standalone PDPs.

2.2 Recruitment

The Henne Group, with assistance from RTI staff, recruited participants for the focus groups in all four locations. We identified potential participants using an extract from the Medicare Beneficiary Database (MBD) supplied by CMS. This database included a list of beneficiaries enrolled in demonstration and non-demonstration plans, who were residents of the county (or counties) within a reasonable distance to the focus group location. For the Wyoming focus groups, beneficiaries resided in the four-county area in the north central region of the state. For the West Palm Beach focus groups, beneficiaries resided in Palm Beach County. For the New York focus groups, beneficiaries resided in New York County, which includes the boroughs of Manhattan and Bronx. For the Los Angeles focus groups, beneficiaries predominately resided in the Santa Monica area of Los Angeles County.

The initial beneficiary files included names, home addresses, and plan type, but no phone numbers. RTI worked with Telematch, Inc. to provide us with a batch file of telephone numbers. We provided these names and phone numbers to The Henne Group to place phone calls to beneficiaries' homes. No other means of recruitment (e.g., flyers, mailers, newspaper ads, etc.) were needed to recruit the number required for each focus group session.

Potential participants were asked if they were currently enrolled in a Medicare Part D drug plan. We could verify this information from our MBD source file, but we wanted to recruit participants who were at a minimum aware they were enrolled in Part D. Our screener questions to verify eligibility were deliberately simple, given the complexity of the Medicare Part D program and potential confusion that could have been created had we asked a detailed set of eligibility questions. During the screening process, we explained to participants that they would need to arrange for their own transportation to the facility. If public transportation was provided near the facility, we shared that information upon request.

Logistics and facilitation of the focus groups was also handled by the Henne Group. We used professional meeting facilities specifically designed for focus groups and other data collection activities (e.g., Murray Hill Center and WAC Research) in all four locations.

2.3 Data Collection Procedures and Analysis

RTI developed a focus group protocol to use as a guide across all locations. This protocol was reviewed and approved by CMS prior to the start of our focus groups. The protocol, attached as *Appendix A* to this report, includes the major discussion topics covered in each focus group session. Each session lasted approximately 75 minutes and none exceeded 90 minutes. Each session was audio-recorded for note-taking purposes. Focus group participants were offered \$75 for their participation in three of the four locations (New York, Los Angeles, and West Palm Beach). Participants were offered \$100 for their participation in the Greybull, WY location to compensate for their longer travel times to reach the facility. Some participants drove over 60 miles one way to Greybull, which was required given the region is very rural. Participants were also provided with drinks and light refreshments during the sessions, and parking fee reimbursements if applicable.

Jeff Henne of The Henne Group facilitated all focus group sessions. Mr. Henne has had extensive experience as a focus group moderator for public health and pharmaceutical clients.

Participants were told to speak one at a time and could freely express their opinions and experiences with Medicare Part D without their responses being tied to their insurance coverage in any way. We assured confidentiality of their identities, and explained that any quotes used for reporting would not be associated back to their names.

We used a thematic approach to analyze the data coupled with a careful review of the audio-tapes to assure quotes recorded were reported accurately. This approach allowed us to compare responses to discussion items or concepts across plan types or experiences with certain aspects of Part D, as well as provide specific participant quotes and examples.

SECTION 3 RESULTS

3.1 Characteristics of Participants

A total of 131 Medicare beneficiaries participated in the focus groups across the four locations from mid- October through early December 2006. Approximately 56% of participants were women. The majority of participants were seniors eligible for the program as they aged in to Medicare upon turning 65. A small number of beneficiaries (one or two per focus group) were disabled. As set by our design, one-quarter of all participants resided in several rural counties located in northwest Wyoming, one-quarter resided in Palm Beach County, FL, one-quarter resided in the Manhattan or Bronx boroughs of New York City, and one-quarter resided in Los Angeles County, CA.

For Group A, all participants were enrolled in a Medicare Advantage prescription drug plan (MA-PD) that offered a payment demonstration enhanced drug plan. For Group B, all participants were enrolled in a standalone prescription drug plan (PDP) that offered an enhanced drug plan also participating in the Part D payment demonstration. For Group C, participants could have been enrolled in any type of basic or enhanced prescription drug plan (MA-PD or standalone PDP) that did not participate in the payment demonstration. Thus, Groups A and B were Part D payment demonstration enrollees and Group C were participants enrolled in some type of basic or enhanced drug plan not participating in the demonstration.

3.2 Regional Characteristics

Greybull, WY. Our first set of focus groups were conducted in this small rural town in northern Wyoming. Participants were recruited from several counties surrounding Greybull, including Big Horn, Park, Hot Springs, and Washakie counties. These counties are outside of any metropolitan statistical areas (MSA) or any other classification of combined statistical areas; thus, the region was quite rural. A number of participants in these groups reported receiving some government assistance, such as coverage under Medicaid or other State program. Residents in these counties did not have access to any Coordinated Care Plans (e.g., HMOs, PPOs, point-of-service plans [POSs]) under Medicare Advantage offering a demonstration enhanced drug plan. The only MA offering participating in the demonstration within these counties was a Private Fee-for-Service (PFFS) plan sponsored by Humana. Residents were also eligible for a Regional PPO plan offered by Blue Cross Blue Shield (BCBS) of Wyoming (partnered with other state Blue plans through the Northern Plains Alliance), but this organization's drug plan options did not include an enhanced plan through the demonstration.

West Palm Beach, FL. Our second set of focus groups were conducted in West Palm Beach, FL. This area of southern Florida attracts a large number of Medicare beneficiaries who retire to Florida from northeastern and mid-Atlantic States. Many participants have been living in Florida for 20 to 30 years, and others have moved into this area of Florida as recently as 2 years ago. Most participants described themselves as reasonably comfortable financially. Palm Beach County has a high Medicare managed care penetration rate and competition is therefore high among Medicare Advantage Organizations and standalone PDPs to attract seniors into a Part D plan. However, Humana was the only local CCP to offer an MA-PD participating in the payment

demonstration for Palm Beach County. Participants had a host of national and regional-based PDPs to choose from in this area.

New York, NY. Our third set of focus groups were conducted in New York, NY. Participants resided in either the Manhattan or Bronx boroughs of New York City. Many participants described themselves as long term New York residents. A number of participants in these focus groups described themselves as being very cost conscious, and about a third of the group described needing some public assistance in addition to Medicare to help pay their medical costs. Similar to southern Florida, New York has a high Medicare managed care penetration rate. Medicare physician payment is high in New York and market competition is fierce, so most Part D plans were zero or near zero premium.

Los Angeles, CA. Our fourth and final set of focus groups were conducted in Los Angeles, CA. Participants resided predominately in the Santa Monica and West LA areas of southern California. A couple of the participants who were not enrolled in a demonstration enhanced plan described receiving some public assistance in addition to Medicare to help pay their costs. Kaiser Permanente was a dominant MA player in the LA area, particularly since all Group A participants were members of Kaiser's MA-PD. Similar to southern Florida and New York, Los Angeles has a high Medicare managed care penetration rate. Participants had a host of national and regional-based PDPs to choose from in this area.

3.3 Decision Process of Part D Plan Choice

MA-PD Demonstration (Group A). Participants in these groups were asked what MA-PD plan they were enrolled in to receive Part D coverage, and to explain in some detail the benefits of the plan. Almost all participants in these groups could name the MA-PD that provided their Part D drug coverage. Some participants could describe their Part D benefits in great detail, whereas others were less clear on the design of their drug coverage. Understanding of the Medicare program in general was lower among participants in the rural Wyoming location than in the West Palm Beach, New York, and Los Angeles markets. For example, one participant in Greybull was unclear as to the relationship between a Part D plan sponsor and the government-financed Medicare program:

- “I’m not on Medicare, I’m told I’m on the Humana Gold plan.”

A number of Group A participants across all markets did not “comparison shop” for their MA-PD plan, but instead remained in their MA plan and thus were rolled into a MA-PD beginning in January 2006. For these participants, the decision process was less complicated and many were therefore unaware of what their Part D drug plan choices were. For instance, many participants enrolled in the Humana Medicare Gold plan prior to 2006 and were told by Humana representatives “not do anything” to receive Part D. As one participant in this situation said,

- “I received a letter that said in big bold letters to not do anything to my health care coverage if I was already satisfied with my plan.”

Another participant in a different location (Los Angeles) made a similar statement:

- “There was no [Part D] decision to make. I was told that if I wanted to remain in my HMO plan that I would be provided with their prescription drug coverage and I would have to do nothing.”

A number of participants in this group, particularly in the Greybull, WY session, reported having initially thought about enrolling in a plan just for Part D (i.e., in a standalone PDP plan). But when they made various attempts to obtain information, for example calling potential organizations that offered a range of MA-PD and PDP products, they decided to enroll in PFFS plans because it seemed like a very good deal. Beneficiaries in this rural area seemed particularly attracted to the zero Part C and D combined premium available from Humana. It appears from these limited focus groups that managed care organizations that offered both standalone PDP and MA-PD products were able to convert a number of beneficiaries from traditional Medicare to MA plans (driven by zero or low combined Part C and D premiums) through the Part D plan selection process. Evidence of “conversions” of traditional Medicare beneficiaries to MA plans was not observed in the other focus group sites, perhaps because PFFS plans with very low (or zero) premiums were not as dominant in these more urban areas. Very few beneficiaries reported having been pressured to join an MA-PD, though they did sense pressure to choose something.

With a few exceptions, participants in these groups were generally confused about their Part D choices and the process of selecting a drug plan. Everyone agreed the process to choose a drug plan was very confusing, as indicated by the following descriptions from participants:

- “Part D is a government sell-out for making it so confusing.”
- “There was a guy who managed an investment fund worth billions...and he couldn’t figure this Part D out. It’s that confusing.”
- “Why do they have to come out and confuse older people? Why don’t they just provide one plan? The person you sit with that explains it to you has 20 plans to go through.”
- “They want to get you enrolled in something, even if you don’t need it.”
- “I don’t understand this...and I’m not stupid. Why don’t they explain this better?”

However, despite their self-professed confusion and frustration, most participants in Group A were able to describe some process of active consideration of choice and a general awareness of what they were enrolled in. They were, overall, generally aware that they had a choice to make in selecting a Part D plan. Many of participants were generally aware that their choice was a plan that was better or more generous than other options. Group A participants noted

- “The lower the premium, the higher everything else costs. They get you one way or the other.”
- “There is a lot that goes into it. There are co-payments for hospitalizations and things. It doesn’t take long to make the \$65 premium pay off.”

PDP Demonstration (Group B). Participants in these groups were asked which standalone PDP plan they were enrolled in to receive Part D coverage, and they were then asked to explain in some detail their understanding of the plan features. Understanding of Part D program features and plan choices was somewhat higher among these groups. Participants in these groups therefore made more informed choices when selecting their Part D plan. A majority of participants told us they did “shop around” for a Part D plan through various sources.

Participants in these groups reported using a myriad of resources and mediums to make an informed choice for their Part D coverage. These individuals may have reported a wider range of resources because, in general, very few were enrolled in any Medicare Advantage plan prior to 2006 and therefore had no option to “do nothing” if they wanted to receive prescription drug coverage. Some participants, particularly those in rural settings, attended seminars conducted at senior centers, pharmacies, or other public facilities to learn more about Part D. These seminars were sometimes conducted by PDP plan sponsors, but we also heard a few participants attended seminars sponsored by SHIPs. A couple of participants could not tell us who sponsored the information seminar. Usually, one or two participants for each focus group used an insurance agent with whom they were already familiar to recommend a Part D plan.

Other participants called into 800-MEDICARE or called directly into a PDP sponsor’s customer service line to get more information. These participants received mailers from PDP sponsors or saw a newspaper ad telling them to call the PDP’s customer service information line. A smaller number of participants used the Web to gather information or make a Part D plan choice. Of those participants that used the Web, the majority went directly to a PDP sponsor Web site to get information. While a small number of participants used the www.medicare.gov prescription drug plan finder, none of these participants said this resource alone helped them arrive to a decision. Advice from an insurance broker was common among participants in this group.

Some participants in these groups felt forced to enroll into a prescription drug plan even though they felt they didn’t need drug coverage. One participant provided this description:

- “I hate the idea of being blackmailed into it, because I don’t need medications. I’m on Medicare. I didn’t need it. But if I waited until next year, I would be penalized and have to pay more money.”
- “A person from Humana was at the Wal Mart pharmacy one day, so I told her my medications and she recommended I enroll in Humana.”
- “My biggest gripe is with the government, and how they’re not allowed to directly negotiate for cheaper drug prices. Why on earth can’t the government do the negotiations, rather than the plans do this themselves?”

Participants in these groups did seem to have some awareness that they had chosen an enhanced plan over basic plans, which were also available. Participants in this group commented on why they chose an enhanced plan over cheaper basic plans:

- “I chose the enhanced plan because you might need it someday.”
- “I was a contractor. You always drop the lowest bidder.”

Non-Demonstration (Group C). With the exception of the Group C session in West Palm Beach, FL, participants in these sessions were able to provide much less information about having participated in an informed decision process compared to the other groups. A number of beneficiaries in these sessions could not accurately describe the name of the plan they were in or the premium they paid. Many seemed to have made their choice based on a single phone call or piece of information (such as a solicitation they received from a plan in the mail). A number of beneficiaries in these groups appeared to have made their decision based on allegiance to a particular “brand” such as AARP or a local Blue Cross Blue Shield product:

- “I’ve always had the AARP.”
- One man just compared five or six plans and decided AARP was “good enough for [him].”

We observed a marked difference in beneficiaries’ understanding that there were choices of Part D products, and that different levels of benefits (basic versus enhanced) were available to them. A number of beneficiaries in these Group C sessions appeared to have been auto-enrolled in plans. Few beneficiaries in this group (with the exception of the West Palm Beach session) described any significant process to gather information. One participant noted that they didn’t use the Internet to consider choices and found the notion of using a computer to make these kinds of decisions to be foreign:

- “Wouldn’t have one of those computers in the house.”

Few individuals in this group used the Internet to make a choice.

The general lack of awareness of the Part D plan choice process among Group C participants in Greybull, New York, and Los Angeles but not in West Palm Beach could be explained a number of ways. One possibility is the fact the West Palm Beach market has a greater proportion of middle and upper socioeconomic status beneficiaries. Fewer beneficiaries in all of the West Palm Beach groups reported receiving government assistance such as Medicaid. Higher socioeconomic status is generally associated with higher levels of education and better understanding of the complex Medicare benefit structure. Therefore, beneficiaries in this market might be better informed overall about Medicare than those beneficiaries in the other three markets. A second possibility is that competing Part D plans might have invested greater marketing and education resources in this highly competitive and relatively high-reimbursed Medicare market.

3.4 Beneficiary Experiences with Part D Plans

In addition to focusing on how the demonstration and non-demonstration groups compared regarding their perception of the Part D plan selection process, we compared the perspectives of these three groups on a range of key Part D issues that beneficiaries were likely

to encounter once they had enrolled in a plan. These key Part D issues were a result of the Part D program as designed in the MMA by Congress and not under the control of CMS or the plans.

3.4.1 The Coverage Gap

MA-PD Demonstration (Groups A). Most participants in Groups A had not encountered the coverage gap. However, over the course of our conducting these focus groups, we noticed that more participants were reaching the coverage gap as the end of the benefit year approached. Typically two to four participants per group had reached the coverage gap. Usually one person in Group A had already reached “the other side” of the gap, where the catastrophic portion of drug coverage from the plan covers 95% of the drug costs. The majority of participants had not encountered the coverage gap; some of them did not even know about the gap in coverage. Typically, they had low prescription drug costs and/or were not being prescribed expensive brand-name medications.

Those in Group A that did encounter the coverage gap or were at least aware of the gap in coverage, were universally dissatisfied that the government would design a gap in drug coverage. Many participants were even willing to pay slightly more in co-payments or premiums to close the coverage gap. Participants whose doctors preferred to prescribe brand-name prescription drugs were particularly distressed with the gap in coverage. None of the plans that focus group participants had enrolled in actually offered brand-name coverage in the gap (but instead covered only generics)¹. Among the Group A participants’ comments on the coverage gap were the following:

- “They just didn’t look far ahead to make the plan work. The Congress doesn’t understand.”
- “We are worse off under Part D than we were when our HMO plan provided prescription drug coverage because of the donut hole. Previously, there was no donut hole so our plan provided better coverage for brand-name prescriptions.”

PDP Demonstration (Group B). Group B participants appeared to have a greater awareness of the coverage gap and understood, in general terms, their plan’s benefit design as it related to the gap in coverage. However, there was significant confusion over how an individual reaches the gap in coverage. For example, many participants in these groups mistakenly thought that they would reach the coverage gap once they paid \$2,250 in out-of-pocket costs. Many participants were shocked to discover that reaching the initial coverage limit was a combination of total drug costs paid by the plans and the individual. This was a concept the majority of participants did not grasp when they enrolled into their Part D plans. Group B participants felt this way regarding the donut hole:

- “I was under the impression that when you went into the donut hole, it would be by how much you spent. But it really depends on what you and the drug company pay for the drugs, so you arrive into the donut hole a lot sooner than you might think.”

¹ Availability of brand name coverage in the gap was available for MA plans in New York, Los Angeles and Palm Beach, but was not generally offered by the managed care organizations with dominant market share.

- “At first I was thrilled I was going to be able to buy into a drug plan. But it was short lived. I was at the donut hole in no time. And there is no plan that is going to cover that for me. I started getting help from my doctors getting samples. This was supposed to help me. It is hurting me. Let it be a legitimate plan.”

Non-Demonstration (Group C). Among the different groups, Group C participants understood the coverage gap least. Several participants from each of these sessions could not explain the coverage gap in the most general terms. Others in this group were not even aware a gap in coverage existed. Among the participants who were at least aware of a lapse in coverage, many didn’t realize it was referred to as the “donut hole.” One participant in this group referred to it as a “black hole” since it was such a confusing concept to grasp.

Many participants in these groups were upset to learn that it was the total drug costs, and not merely their co-payment/coinsurance payments, that would count toward the initial coverage limit (typically \$2,250). In West Palm Beach, all Group C participants had this false impression about encountering the coverage gap. They commented that the literature and spokespeople representing the Part D plans relayed very confusing information about what counted toward the coverage gap. One possible explanation for this difference in level of knowledge about coverage gaps between the demonstration and non-demonstration groups might be related to the apparently greater proportion of auto-enrolled and/or subsidy-eligible beneficiaries in these groups. Beneficiaries eligible for certain subsidies do not face coverage gaps to the same degree as beneficiaries who are all enrolled in an enhanced plan.

3.4.2 Out-of-Pocket Costs

MA-PD Demonstration (Group A). Participants in Group A had different experiences and attitudes towards the out-of-pocket costs (e.g., deductibles, co-payments, coinsurance, costs in the gap) required under their plans. Most participants were pleased with the modest co-payment amounts required within the initial coverage limit, and many credited their Part D plan for bringing down their prescription drug costs in previous years. Co-payments for generic prescription drugs were somewhat cheaper than co-payments for brand-name prescription drugs under the plans, and the simpler their co-pay tier system for drugs, the more satisfied participants were. One participant noted this regarding the design of Part D plans and tiered co-payments:

- “To be simple is scientific, and to be scientific is simple. Too many tiers is too much confusion.”

In some instances, participants perceived that their costs were higher under Part D than previously under an MA plan with prescription drug coverage.

Another common theme among Group A participants was the price they had to pay for drugs once they entered the coverage gap. A number of participants complained that these prices were too high, and in some cases higher than they had been paying before they got Part D coverage, particularly if they were getting their drugs from Canada. One Group A participant noted:

- “The price I have to pay is more than Canada. It’s atrocious. It’s \$30 a month for the prescription.”

Other participants noted that the prices of the drugs keep increasing. A number of participants in this group obtained their drugs through the mail to lower their co-payments. Another concern raised among this group was difficulty knowing in advance what a drug was going to cost under a plan. One woman went into the store to find out what a prescription would cost under her plan. She couldn't get a price. She then called her plan to get a price, but the plan said they could only give her an estimate. The impression this beneficiary took away was that the price she would have to pay was always changing, and she found her plans' inability to quote her a consistent price was frustrating.

PDP Demonstration (Group B). Most participants in the Group B sessions understood they were enrolled in a plan that offered more coverage than the basic plans available. Similar to Group A participants, they expressed a great deal of frustration about the overall costs of drugs and the costs faced when they entered the coverage gap. A number of participants were frustrated that they were paying higher prices, even with coverage, than when they purchased drugs from Canada. One participant noted,

- “When is the government going to be able to negotiate prices for drugs? That is the dumbest thing.”

Other participants felt they had better, cheaper coverage before Part D:

- “I think I was better off when I had my AARP supplemental. But once this Part D came in all of that died. You can't get that kind of thing anymore.”

On the other hand, some Group B participants felt they were better off now with at least some coverage. A number of individuals in one session even noted that they may be paying more now under the Part D plan than before, and aren't happy about it, but that there is some insurance protection:

- “Don't lose sight of the insurance value ... You could be hit with \$100,000 a month. Something could happen later...”

Non-Demonstration (Group C). As with other issues, Group C participants offered fewer specific comments regarding their out-of-pocket costs under Part D beyond the general observation that prescription drugs ought to be cheaper. We actually found that, on a self-reported basis, Group C participants were often paying higher monthly premiums for their plans than their Groups A and B counterparts within the same market. Some of this is explained by the fact that these participants seemed most attached to specific organizations like AARP and Blue Cross Blue Shield, who often had higher premiums in the market even if they were not always providing enhanced benefits.

Similar to our findings for the demonstration plan participants (Groups A and B), a number of Group C participants did reference drug prices in Canada as a standard that should be applied to Medicare. A participant in the Florida Group C session figured out that he wasn't going to make it out of the coverage gap, so he was better off purchasing his medications from Canada. Others in this group who have previously purchased medications from Canada will obtain some of their drugs through their Part D plan and some outside the system from Canada:

- “Some of these Canadian drugs are just half the price of what the American drug companies charge when you are in the donut hole.”

3.4.3 Plan formularies, Brand vs. Generic Drug Issues

MA-PD Demonstration (Group A). The large majority of participants understood their plans’ drug formularies, and were able to discern whether their medications were included or not included in their plan’s formulary. A few participants expressed some dissatisfaction that a particular medication their doctor recommended was not included on the plan’s formulary, but participants generally accepted formularies as a way for plans to contain overall costs and control drug utilization.

Participants in this group reported being able to obtain some of the brand-name drugs approved by request from their physicians. Another Group A participant saw the use of the formularies and brand versus generic requirements this way:

- “Medicare is becoming the doctor.”

Some participants said their doctors preferred prescribing the brand-name drug even when a generic equivalent was available. These participants seemed more willing to comply with their doctors’ requests than ask for the generic equivalent. As one observer noted:

- “He’s my doctor, so I trust his judgment more than my own when it comes knowing what works best for me.”

PDP Demonstration (Group B). Similar to Group A, Group B participants also seemed generally to understand that their plan may limit coverage of certain drugs through the use of formularies and other mechanisms. In general, participants in this group reported few problems obtaining the drugs they needed. However, some beneficiaries in this group found the process harder than they thought it should be. One participant noticed that his plan can drop a drug from its formulary in mid-year. Another participant noticed that some drugs that use to be classified as just generic:

- “Now they are preferred generic. This is just another way to control access to drugs.”

Other participants in this group found that even representatives of their plan had difficulty explaining how the formulary and tiers worked:

- “People I talk to on the phone about generic versus non generic, and what is what, don’t really know anyway.”

Others commented on the complexity this adds:

- “Under my old coverage, you didn’t have to know all this. Now at a time when I want my brain to know less, I have to know more.”

Non-Demonstration (Group C). Once again, participants in the Group C sessions had fewer specific comments about Part D plan formularies, drug tiers, and other related details. Participants in these groups appeared to have much less awareness of these issues.

3.5 Satisfaction with Part D

In addition to discussing the specific experiences described in the previous section, we also asked participants in each group to describe their overall satisfaction with the plan on a scale of 1 (lowest) to 10 (highest). Participants were asked to record their rating on paper, and only when all participants had selected a rating, share these with the group. Table 1 summarizes the responses across all groups and sites.

Table 1
Mean overall satisfaction scores

Site	Group A MA-PD demonstration participants	Group B PDP demonstration participants	Group C non-demonstration participants
Palm Beach, FL	8.6 (n=9)	6.2 (n=10)	7.8 (n=10)
New York, NY	5.9 (n=11)	3.9 (n=11)	3.6 (n=8)
Los Angeles, CA	6.7 (n=10)	7.0 (n=11)	6.0 (n=6)
Greybull, WY	7.0 (n=9)	9.3 (n=11)	9.6 (n=8)

NOTES: Some participants did not provide a score. Average scores are for those who offered an overall “score” during the session.

SOURCE: RTI analysis of data collected during focus groups.

In general, enrollees in Group A (MA-PD demonstration plan enrollees) reported greater satisfaction with their plan compared to Group C (non demonstrations plan enrollees) within the same market. The exception was in Greybull, the rural site, where this relationship was reversed. In Greybull, the lowest satisfaction was reported by MA-PD demonstration enrollees. Many of the MA-PD participants in Greybull enrolled in a PFFS plan option.

MA-PD Demonstration (Group A). Across all four sites, Group A participants provided a mean score of 6.3. Many participants were satisfied and scored their Part D plan a 9 or 10. A similar share of participants was somewhat dissatisfied and scored their plan as low as 1, but more commonly a 3 or 5. When participants explained their satisfaction scores, they were generally satisfied with the MA-PD organization but dissatisfied with the “Medicare program” or the “government” for designing Part D in the manner it did. Among those participants who did not view the government favorably, many blamed Congress or the president for passing the legislation that created Part D.

PDP Demonstration (Group B). Group B participants’ mean satisfaction score of 6.5 was similar to that the MA-PD demonstration participants provided (6.3). Some participants who were not regularly taking medications opted to not give a satisfaction score since they had no

experience using their coverage. These participants had typically enrolled in a Part D plan as a precautionary measure so they would have drug coverage if they became ill or needed unforeseen medications. Others felt “forced” into enrolling in a Part D plan because of the late enrollment penalty and the perceived urgency of the Medicare program. Thus, participants who enrolled in the program for these stated reasons were dissatisfied with “Part D,” “Medicare,” or the “government”—but not necessarily dissatisfied with their PDP.

Non-Demonstration (Group C). Group C participants’ mean satisfaction score of 5.4 was somewhat lower than the mean score of Groups A and B. It should be noted that Group C participants could have been enrolled in a myriad of PDP plan types, including basic drug plans that don’t provide the richer coverage packages provided by the enhanced drug plans.

SECTION 4

SUMMARY OF COMPARTISONS BETWEEN DEMONSTRATION AND NON- DEMONSTRATION FOCUS GROUP PARTICIPANTS

A number of perspectives were expressed across all three focus group types about the Part D program as designed in the MMA by Congress. These more universal findings, in which we observed no differences among enrollees in demonstration versus non-demonstration plans, were as follows:

- **The Part D program is confusing.** Participants in all focus groups found the program complicated and difficult to understand. Even beneficiaries in relatively sophisticated markets, with relatively long standing experience with multiple Medicare coverage options, reported that they had difficulty understanding the Part D program and making a plan choice. Confusion over issues such as what expenditures count towards the initial coverage limit (many beneficiaries across all sites thought only enrollee cost sharing counted, not the full cost of the drug), whether there was any coverage in the gap, and existence of plan specific formularies were nearly universal.
- **The coverage gap should be eliminated.** Beneficiaries thought this was a real hardship for beneficiaries, who have a hard time affording their drugs or even planning their costs.
- **Medicare beneficiaries should pay less for drugs.** The groups differed, however, on how they thought this should be accomplished. Participants in Groups A and B often suggested that the government should directly negotiate with the pharmaceutical drug makers for cheaper prices along the lines of the Canadian model. Participants in Group C were less specific but thought prices were too high.
- **Beneficiaries were eventually able to get needed medications.** We often heard that this process could be complicated, and that the prices that were paid for some drugs (particularly brand name) were sometimes much higher than they expected. Still, across groups, it appears that beneficiaries generally felt they were able to get what they needed. A few beneficiaries who participated in the focus groups had experienced appealing denials of coverage for specific brand name drugs. Most reported that they were eventually successful but reported that this process took what they felt was a long time.

Despite these commonalities, we noted a number of important differences among the enrollees in demonstration versus non-demonstration plans:

- **Enrollees in demonstration plans were much more aware of having a range of choices, particularly choices among basic and enhanced benefit packages.** Demonstration plan enrollees across all sites (Groups A and B) appear to have engaged in a much more deliberate process for making a Part D plan choice. This may be related to an observation that enrollees in the demonstration enhanced plans were more likely to describe themselves as holding professional jobs, and may

therefore have had higher levels of education. Higher levels of education may theoretically have better prepared beneficiaries to make informed choices.

- **Enrollees in demonstration plans were generally more knowledgeable about Part D plan benefit details.** With the exception of non-demonstration plan enrollees in West Palm Beach, Group C enrollees knew much less about key Part D plan features (such as the coverage gap).
- **Enrollees in the demonstration plans, based on their self-descriptions, appeared on average to be healthier and consume fewer drugs than the non-demonstration enrollees.** It was expected that enrollees in demonstration enhanced plans to have greater drug needs compared to the non-demonstration enrollees who were overwhelmingly enrolled in basic plans. The opposite appeared to be true; that demonstration plan enrollees described themselves generally as needing fewer drugs than many of the non-demonstration enrollees, who commonly described themselves as having complex medical needs and requirements for a wide range of drugs. This finding might be explained by a greater representation of higher income beneficiaries, with better on average health status, having a greater ability to pay higher enhanced plan premiums.

The limitations of focus group analysis do not allow us to definitively identify reasons for these observed differences among the groups. However, we were able to identify a number of potential explanations. First, enrollees in demonstration plans are, by definition, all enrolled in enhanced plan products. These products are often (but not always) more expensive than comparable products available in the marketplace. Therefore, beneficiaries willing to pay additional money may also have been more willing to invest time and energy in gathering information to make an informed choice. Second, enrollees in the demonstration plans were much more likely to describe themselves as having professional jobs. These groups also appeared to be more highly educated and were therefore more able to gather and understand the necessary information needed to become aware of program options, benefits and costs. Third, though we have no direct evidence, organizations that chose to participate in the demonstration in order to offer enhanced benefits might also have done a better job of educating potential enrollees about their products and those product features. Finally, beneficiaries receiving government subsidies were eligible to enroll in only basic plans (unless they chose to pay higher premiums, which few have). These beneficiaries of lower socioeconomic status may have either been auto-assigned to plans, and/or because of the subsidies they receive, had little incentive to choose carefully among plan choices.

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**APPENDIX A: PART D PAYMENT DEMONSTRATION BENEFICIARY FOCUS
GROUP DISCUSSION GUIDE**

Part D Payment Demonstration Beneficiary Focus Group Discussion Guide

September 29, 2006

Begin with introductions, short explanation of the purpose of the focus group.

As you know, the Medicare program began a new prescription drug benefit this year. Everyone we've asked to participate in this focus group today is receiving benefits under this new Medicare prescription drug. The federal government agency that runs the Medicare program—the Centers for Medicare and Medicaid Services or CMS—has asked RTI, International and The Henne Group to talk to Medicare beneficiaries about the prescription drug program to get some feedback on how you chose your plan and how that plan is working for you.

1. DECISION PROCESS FOR PLAN CHOICE

a. What type of insurance coverage for prescription drugs do you have, if any?

- i. *See if beneficiaries can describe their current coverage in any detail*
- ii. *Are they aware of whether they are enrolled in Medicare Part D or not.*
- iii. *Do they accurately describe whether they are enrolled in a standalone PDP versus an MA-PDP?*
- iv. *For those in the non-demonstration focus group, do they have any sense of being enrolled in either standard or enhanced benefit package?*

b. What choices did you have for prescription drug coverage? What factors influenced your choice of prescription drug coverage?

- i. *Are these beneficiaries aware that there are potentially different levels of coverage (basic versus enhanced)? Or do they simply perceive an array of benefits that have different costs?*
- ii. *Have the beneficiaries walk through their choice process. The choices for drug coverage that they were aware of, the choices they seriously considered what information they obtained about the alternatives (and from where), who assisted or influenced them in choosing, and how they chose.*
- iii. *Was there something specific about the enhanced package that was more attractive (better coverage, less out of pocket), or not attractive (higher premium)?*

- iv. *Alternatively, do beneficiaries simply purchase what they can afford without understanding the specific levels of benefits?*
- v. *Probe focus group participants who enrolled in enhanced coverage whether they would have enrolled in standard coverage if enhanced coverage was not available.*
- vi. *Probe for importance (if feasible) of factors like out of pocket costs, premium level, co-payment level, pharmacy access, coverage of all drugs.*
- vii. *Are beneficiaries aware of the “donuthole” and the catastrophic coverage limit? Have they reached it? Do they understand it is annual (it will happen every year)? Did it come as a surprise?*
- viii. *Probe if beneficiaries were aware of the late enrollment penalty of 1% per month, and if so, did that affect their decision to enroll?*
- ix. *Probe how the person’s utilization of drugs affected their enrollment decision. E.g., if they are a low utilizer (e.g., take no drugs), did they simply choose the cheapest, basic plan? If they are a high utilizer (take many drugs, have high expenditures) were the enhanced plans (especially the fixed option) particularly attractive to them?*

2. BENEFICIARY EXPERIENCES WITH PLANS

- a. **Describe your experiences with using Part D plan. Are you happy with your plan?**
 - i. *Look specifically for any satisfaction differences between enrollee in demonstration enhanced versus other benefit packages.*
 - ii. *How do enrollees react to any information received from plans, particularly information and contacts that urge them to do things like use more generic drugs? How do they view the information they get from their plans?*
 - iii. *Are these focus group participants planning to remain with the same plan next year?*
 - iv. *Do they feel their current drug coverage this year—under Part D—was better compared to previous years?*
 - v. *Do they feel more secure and protected against large prescription drug expenditures this year under Part D compared to previous years?*

b. Have you been able to get all the drugs you need?

- i. Have they experienced the “donut hole”? How did that affect their ability to get drugs?*
- ii. Probe reasons for problems with access, if possible (e.g., Part D plan utilization strategies such as prior authorization). What caused the problem? Did the plan not authorize the drug? Was it a generic versus brand name problem? Some other problem?*

c. Have getting your drugs been convenient—either through a pharmacy, mail order or both?

- i. Probe reasons for where they choose to get their drugs, particularly differences between folks who use mail order versus pharmacies.*

d. Are your costs about what you expected?

- i. Have they saved money versus their previous coverage?*
- ii. Do they feel like their current drug coverage is “worth the money”? A good value?*